MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8927

CERTIFICATE OF DEATH

08899

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Fredrick
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Calvert Nursing Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CLARA Middle CECELIA Last GIBBENS

4. DATE OF DEATH: Month Aug Day 12 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Charles Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Simon Bowie
14. MOTHER'S MAIDEN NAME: Mary C. Burgess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Address: Miss. Jennie R. Bowie - La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours.
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive C.V. disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/2, 1959 to 8/12, 1959, that I last saw the deceased alive on 8/12, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Page S. Jett M.D. — ADDRESS (Street, city or town, state): Prince Frederick — DATE SIGNED: 8/13/59

PHYSICIAN'S NAME (Type): Page S. Jett — Prince Frederick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/15/1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Rest Cemetery
22d. LOCATION (City, town, or county) (State): La Plata, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Urehart Funeral Home, Inc.
AREHART FUNERAL HOME, INC. * LA PLATA, MD.

24a. REC'D BY REGISTRAR DATE: AUG 18 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8928 **CERTIFICATE OF DEATH** Reg. Dist. No. 08900

1. PLACE OF DEATH
a. COUNTY Calvert MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown
c. LENGTH OF STAY IN 1b 5 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dutch's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Leonards
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROSY Middle FLORENCE Last GOTT

4. DATE OF DEATH Month Aug Day 27, Year 1959

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 27, 1880

9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY Unemployed

11. BIRTHPLACE (State or foreign country) Calvert Co., Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John T. Gott

14. MOTHER'S MAIDEN NAME Isabelle Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. No

17. INFORMANT Address Mrs Lawrence Johnson - Owings, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal Desease — INTERVAL BETWEEN ONSET AND DEATH 4 yrs

DUE TO (b) Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 58 to Aug 21 1959, that I last saw the deceased alive on Aug 21 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE H. W. Ward M.D. ADDRESS (Street, city or town, state) Owings Md DATE SIGNED 8/29/59

PHYSICIAN'S NAME (Type) H. W. WARD OWINGS MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Aug. 30, 1959

22c. NAME OF CEMETERY OR CREMATORY Water's Memorial Cem.

22d. LOCATION (City, town, or county) Calvert Co., Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son ADDRESS Mutual, Md.

24a. REC'D BY REGISTRAR DATE SEP 1 '59

24b. REGISTRAR'S SIGNATURE Corinne S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8929

CERTIFICATE OF DEATH

08901

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Fredrick
c. LENGTH OF STAY IN 1b: 1 year 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Calvert Nursing Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Geo, Anne Arun
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cottage City 16 x 2
d. STREET ADDRESS: 3704 42ND. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: minnie — Middle: C. — Last: Haddaway

4. DATE OF DEATH: Month: 8 — Day: 7. — Year: 1959

5. SEX: Female.

6. COLOR OR RACE: White.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5 1887.

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Washington DC

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank. B. Curtis.

14. MOTHER'S MAIDEN NAME: Alice. Burnett.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-12-9315

17. INFORMANT: Henry C. Haddaway — Address: 3704 42nd Ave Cottage City Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	1 day
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic C.V. Disease	?
DUE TO (c)	Decubetus Ulcers	8 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1959, to Aug 7, 1959, that I last saw the deceased alive on Aug 7, 1959, and that death occurred at 11 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Page C Jett M.D. — ADDRESS (Street, city or town, state): Prince Frederick — DATE SIGNED

PHYSICIAN'S NAME (Type): PAGE C JETT — Prince Fredrick — 8/8/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/10/59 — 22c. NAME OF CEMETERY OR CREMATORY: Rock Creek — 22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers & Son — ADDRESS: 517 11th St S.E.

24a. REC'D BY REGISTRAR DATE: AUG 12 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8930

CERTIFICATE OF DEATH

08902

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Frederick
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Calvert County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olivet
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Johnson, Jr.

4. DATE OF DEATH: Month: August — Day: 25 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 24, 1928

9. AGE (In years last birthday): 31 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vincent Johnson

14. MOTHER'S MAIDEN NAME: Christine Philip

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-26-0712

17. INFORMANT: Address: Oruzila Johnson, Olivet, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure due to
581.0
DUE TO
(b): Carcinoma of Cervix
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____ to Aug 25, 1959 that I last saw the deceased alive on ____, 19____, and that death occurred at ____ M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. de Villarreal M.D.

ADDRESS (Street, city or town, state): St Leonard

DATE SIGNED: 8/25/59

PHYSICIAN'S NAME (Type): Roberto de Villarreal, M. D. — St. Leonard, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF: 8-28-59

22c. NAME OF CEMETERY OR CREMATORY: St. Johns

22d. LOCATION (City, town, or county) (State): Huntingtown Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: P. E. Sewell, Pr. Fred, Md.

24a. REC'D BY REGISTRAR DATE: SEP 2 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8931 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08903

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 702 Marshall Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Theodore — Middle: — Last: Piechota
4. DATE OF DEATH: Month: 8 — Day: 26 — Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 3 1945
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore Piechota
14. MOTHER'S MAIDEN NAME: Esther Gallagher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Theodore Piechota 117 Johnson St Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drown — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was in boat near C.B. and done of Exposure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: 4 a.m. p.m. — Month, Day, Year: 8/26 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay
20f. (City or town) Chesapeake Beach (County) Calvert (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: H W Ward M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/28/59
EXAMINER'S NAME (Type): H. W. WARD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-31-59
22c. NAME OF CEMETERY OR CREMATORY: Pittson
22d. LOCATION (City, town, or county) (State): Grantsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hutchins Funeral Home — ADDRESS:
24a. REC'D BY REGISTRAR DATE: SEP 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08904

8932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W Beach
c. LENGTH OF STAY IN 1b: TRANSIENT
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): X

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: D C — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1351 4th St SW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Allen — Last Richards
4. DATE OF DEATH: Month 8 — Day 15 — Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 23/1940
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tow Truck Operator
10b. KIND OF BUSINESS OR INDUSTRY: Garage
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Edward Granville Richards Jr
14. MOTHER'S MAIDEN NAME: Ruby Elaine Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Edward G. Richards, Jr. — Address: 1351 - 4th St SW Wash D C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broken neck and multiple
DUE TO (b): Diving at U.S. Naval Ord Plant
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Auto accident July
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Diving
20c. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. 4:15 — 8 15 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): W Beach
20f. (City or town) Calvert — (County) — (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: H W Ward M.D.
EXAMINER'S NAME (Type): H. W. WARD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/15/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-19-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington Memorial Cemetery
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS Co.
ADDRESS: 577-11th St SE. Wash. D.C.

24a. REC'D BY REGISTRAR: DATE AUG 20 59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8933 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11207

Reg. Dist. No.

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Calvert — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Calvert
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Frederick — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North Beach
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert County Hospital	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Roy	William	Sandt	August	22	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		3/1/01	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
	166-18-2322	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): and Brown atrophy of heart

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Charles S. Petty M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED 8/23/59

[redacted]'S NAME (Type) Charles S. Petty

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	10.16.59	U. of Md. Med. School	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
	OCT 21 '59	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8934

CERTIFICATE OF DEATH

Reg. Dist. No. 08905

1 PLACE OF DEATH
a. COUNTY Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland — b. COUNTY Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print) First T. Middle CARLTON Last SCRIVENER
4. DATE OF DEATH Month Aug. Day 29, Year 1959

5. SEX M
6 COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH Nov. 10, 1878
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min. —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Calvert Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Charles W. Scrivener
14. MOTHER'S MAIDEN NAME Christiana V. Kelton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO 217-36-7179
17. INFORMANT Maurice Scrivener Address Catonsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition - Dehydration
DUE TO (b) Uremia —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) — Mentally disturbance
INTERVAL BETWEEN ONSET AND DEATH: 6 Months (?)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 57 to Aug 29 1959 that I last saw the deceased alive on Aug 29, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE M.D. ADDRESS (Street, city or town, state) Stephens DATE SIGNED 8/29/59
PHYSICIAN'S NAME (Type) R. DE VILLARREAL M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF Aug. 31, 1959
22c. NAME OF CEMETERY OR CREMATORY Central Cemetery
22d LOCATION (City, town, or county) (State) Barstow, Calvert Co. - Md

23 FUNERAL DIRECTOR'S SIGNATURE O. A. Parkinson & Son - Mutual, Md.
ADDRESS
24a. REC'D BY REGISTRAR DATE SEP 1 '59
24b. REGISTRAR'S SIGNATURE Cortland S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

Stam 26 Film 348 8-13-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8935

08906 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dowell
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C
d. STREET ADDRESS 1101 7th ST. SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FRANCIS Middle SLYVESTER Last THOMAS
4. DATE OF DEATH Month 8 Day 2 Year 59 19

5. SEX M
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12/26/32
9. AGE (In years last b'rthday) 26 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME TOMMY THOMAS
14. MOTHER'S MAIDEN NAME DORA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drown
927.8
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found off Flat Sandy Point MD
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diver [illegible] in the Patuxent River about 5 miles of Benedict when he jumped from a boat for a swim while fishing
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 8-2-59 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Patuxent River
20f. (City or town) Benedict (County) Charles (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE H W Ward M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8/15/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9 Aug '59
22c. NAME OF CEMETERY OR CREMATORY St. John
22d. LOCATION (City, town, or county) (State) Milford, Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE AUG 13 '59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8936

CERTIFICATE OF DEATH

08907

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Calvert — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Republic
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Calvert
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Port-Republic
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Phillip — Last: Wall
4. DATE OF DEATH: Month: 8 — Day: 15 — Year: 1959

5. SEX: M.
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29. 58
9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months: 6 — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wall.
14. MOTHER'S MAIDEN NAME: Ella Harrod.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ella Harrod. — Address: Port-Republic

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Whooping Cough
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

056.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-8, 1959, to 8-11, 1959, that I last saw the deceased alive on 8-14, 1959, and that death occurred at 2 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Huntingtown Md — DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. (BURIAL) CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 8-16-59
22c. NAME OF CEMETERY OR CREMATORY: Browns
22d. LOCATION (City, town, or county) (State): Port Republic, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: P. T. Sewell, Prince Fred. Md.
24a. REC'D BY REGISTRAR DATE: AUG 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

8937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08908

Reg. Dist. No.

064

M

1. PLACE OF DEATH a. COUNTY: Calvert MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D C b. COUNTY: Wash
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Prince Frederick / c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC 47X-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert Co H	d. STREET ADDRESS: 804 ... / e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print) First: Henry Middle: Last: Yates	4. DATE OF DEATH Month: 8 Day: 14 Year: 1959
5. SEX: M / 6. COLOR OR RACE: W / MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Dec 8-1891 / 9. AGE (In years last birthday): 67 yrs. / IF UNDER 1 YEAR: Months, Days / IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter / 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Virginia / 12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Theodore B Yates	14. MOTHER'S MAIDEN NAME: Kate Hudson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No / 16. SOCIAL SECURITY NO.	17. INFORMANT: Theodore B Yates Address: 5804-N St. S.E. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure

260X

DUE TO (b) Hav diabetes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was ... a boat when found dead ...

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour 4 a.m. p.m. Month, Day, Year 8/14 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches Bay

20f. (City or town) (County) (State) Ches. Beach Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE H W Ward M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 8/14/59

EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 18/59	Cedar Hill Cem.	Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Lee. Funeral Home 300 4th St. Washington D.C.	DATE AUG 18 '59	Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VS. A15ME(5)

5M 9/55